

# **ENGROSSED HOUSE BILL No. 1075**

DIGEST OF HB 1075 (Updated March 30, 2005 1:04 pm - DI 104)

Citations Affected: IC 27-8; IC 27-13; noncode.

**Synopsis:** Health insurance waivers. Provides that an individual policy of accident and sickness insurance and certain association and discretionary group policies of accident and sickness insurance may contain a waiver of coverage for a specified condition if certain requirements are met. Specifies that an offer of coverage under a policy that includes a waiver does not preclude eligibility for a comprehensive health insurance association policy. Allows, under certain circumstances, an accident and sickness insurer or a health maintenance organization to provide a policy or contract without complying with all health benefit mandates. Requires insurers and health maintenance organizations to report specified information to the department of insurance (department) concerning these policies and contracts. Requires the department to report this information and other specified information to the legislative council.

Effective: July 1, 2005.

## Torr, Brown C, Burton, Ripley

(SENATE SPONSORS — MILLER, SIMPSON, PAUL)

January 6, 2005, read first time and referred to Committee on Insurance. January 13, 2005, amended, reported — Do Pass. January 24, 2005, read second time, amended, ordered engrossed. January 25, 2005, engrossed. Read third time, passed. Yeas 76, nays 14.

SENATE ACTION

February 14, 2005, read first time and referred to Committee on Health and Provider

March 31, 2005, amended, reported favorably — Do Pass.



First Regular Session 114th General Assembly (2005)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2004 Regular Session of the General Assembly.

# ENGROSSED HOUSE BILL No. 1075

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

1	SECTION 1. IC 27-8-5-2.7 IS ADDED TO THE INDIANA CODI
2	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
3	1, 2005]: Sec. 2.7. (a) Notwithstanding section 2.5 of this chapter
4	an individual policy of accident and sickness insurance may
5	contain a waiver of coverage for a specified condition and any
6	complications that arise from the specified condition if:
7	(1) the waiver period does not exceed ten (10) years; and
8	(2) all of the following conditions are met:
9	(A) The insurer provides to the applicant before issuance
10	of the policy written notice explaining the waiver o
11	coverage for the specified condition and complication
12	arising from the specified condition.
13	(B) The:
14	(i) offer of coverage; and
15	(ii) policy;

include the waiver in a separate section stating in bold

print that the applicant is receiving coverage with an

EH 1075—LS 6834/DI 97+











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1	exception for the waived condition.	
2	(C) The:	
3	(i) offer of coverage; and	
4	(ii) policy;	
5	do not include more than two (2) waivers per individual.	
6	(D) The waiver period is concurrent with and not in	
7	addition to any applicable preexisting condition limitation	
8	or exclusionary period.	
9	(E) The insurer agrees to:	
10	(i) review the underwriting basis for the waiver upon	- 1
11	request one (1) time per year; and	
12	(ii) remove the waiver if the insurer determines that	
13	evidence of insurability is satisfactory.	
14	(F) The insurer discloses to the applicant that the applicant	
15	may decline the offer of coverage and apply for a policy	
16	issued by the Indiana comprehensive health insurance	4
17	association under IC 27-8-10.	
18	(G) The waiver of coverage does not apply to coverage	
19	required under state law.	
20	(H) An insurance benefit card issued by the insurer to the	
21	applicant includes a telephone number for verification of	
22	coverage waived.	
23	The insurer shall require an applicant to initial the written notice	
24	provided under subdivision (2)(A) and the waiver included in the	
25	offer of coverage and in the policy under subdivision (2)(B) to	
26	acknowledge acceptance of the waiver of coverage. An offer of	
27	coverage under a policy that includes a waiver under this	1
28	subsection does not preclude eligibility for an Indiana	
29	comprehensive health insurance association policy under	1
30	IC 27-8-10-5.1.	
31	(b) Notwithstanding subsection (a):	
32	(1) an individual policy of accident and sickness insurance	
33	may not include a waiver of coverage for:	
34	(A) a mental health condition;	
35	(B) a developmental disability; or	
36	(C) diabetes as required under IC 27-8-14.5; and	
37	(2) an insurer that issues an individual policy of accident and	
38	sickness insurance shall comply with the requirements	
39	concerning victims of abuse under IC 27-8-24.3.	
40	(c) An insurer may not, on the basis of a waiver contained in a	
41	policy as provided in subsection (a), deny coverage for any	
42	condition, complication, service, or treatment that is not specified	



1	as required in the:	
2	(1) written notice under subsection (a)(2)(A); and	
3	(2) offer of coverage and policy under subsection (a)(2)(B).	
4	(d) An individual who is covered under a policy that includes a	
5	waiver under subsection (a) may directly appeal a denial of	
6	coverage based on the waiver by filing a request for an external	
7	grievance review under IC 27-8-29 without pursuing a grievance	
8	under IC 27-8-28.	
9	(e) An insurer that removes a waiver under subsection (a)(2)(E)	
10	shall not consider the condition or any complication to which the	
11	waiver previously applied in making policy renewal and	
12	underwriting determinations.	
13	(f) Upon the expiration of the waiver period allowed under this	
14	section, the insurer shall:	
15	(1) remove the waiver;	
16	(2) not consider the condition or any complication to which	
17	the waiver previously applied in making policy underwriting	
18	determinations; and	
19	(3) renew the policy in accordance with 45 CFR 148.122.	
20	SECTION 2. IC 27-8-5-19.3 IS ADDED TO THE INDIANA CODE	
21	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY	
22	1, 2005]: Sec. 19.3. (a) This section applies to an association or a	
23	discretionary group policy of accident and sickness insurance:	
24	(1) under which a certificate of coverage is issued to an	
25	individual member of the association or discretionary group;	
26	(2) under which a member of the association or discretionary	
27	group is individually underwritten; and	7
28	(3) that is not employer based.	
29	(b) Notwithstanding sections 19 and 19.2 of this chapter, a policy	1
30	described in subsection (a) may contain a waiver of coverage for a	
31	specified condition and any complications that arise from the	
32	specified condition if:	
33	(1) the waiver period does not exceed ten (10) years; and	
34	(2) all of the following conditions are met:	
35	(A) The insurer provides to the applicant before issuance	
36	of the policy written notice explaining the waiver of	
37	coverage for the specified condition and complications	
38	arising from the specified condition.	
39	(B) The:	
40	(i) offer of coverage; and	
41	(ii) certificate of coverage;	
42.	include the waiver in a senarate section stating in bold	



1	print that the applicant is receiving coverage with an	
2	exception for the waived condition.	
3	(C) The:	
4	(i) offer of coverage; and	
5	(ii) certificate of coverage;	
6	do not include more than two (2) waivers per individual.	
7	(D) The waiver period is concurrent with and not in	
8	addition to any applicable preexisting condition limitation	
9	or exclusionary period.	
10	(E) The insurer agrees to:	
11	(i) review the underwriting basis for the waiver upon	
12	request one (1) time per year; and	
13	(ii) remove the waiver if the insurer determines that	
14	evidence of insurability is satisfactory.	
15	(F) The insurer discloses to the applicant that the applicant	_
16	may decline the offer of coverage, and that any individual	
17	to whom the waiver would have applied may apply for a	
18	policy issued by the Indiana comprehensive health	
19	insurance association under IC 27-8-10.	
20	(G) The waiver of coverage does not apply to coverage	
21	required under state law.	
22	(H) An insurance benefit card issued by the insurer to the	
23	applicant includes a telephone number for verification of	
24	coverage waived.	
25	(c) The insurer shall require an applicant to initial the written	
26	notice provided under subsection (b)(2)(A) and the waiver included	
27	in the offer of coverage and in the certificate of coverage under	
28	subsection (b)(2)(B) to acknowledge acceptance of the waiver of	V
29	coverage.	
30	(d) An insurer may not, on the basis of a waiver contained in a	
31	policy as provided in this section, deny coverage for any condition,	
32	complication, service, or treatment that is not specified as required	
33	in the:	
34	(1) written notice under subsection (b)(2)(A); and	
35	(2) offer of coverage and certificate of coverage under	
36	subsection (b)(2)(B).	
37	(e) An individual who is covered under a policy that includes a	
38	waiver under this section may directly appeal a denial of coverage	
39	based on the waiver by filing a request for an external grievance	
40	review under IC 27-8-29 without pursuing a grievance under	
41	IC 27-8-28.	
12	(f) An offer of coverage under a policy that includes a waiver	



1	under this section does not preclude eligibility for an Indiana
2	comprehensive health insurance association policy under
3	IC 27-8-10-5.1.
4	(g) An insurer that removes a waiver under subsection (b)(2)(E)
5	shall not consider the condition or any complication to which the
6	waiver previously applied in making policy renewal and
7	underwriting determinations.
8	(h) Upon the expiration of the waiver period allowed under this
9	section, the insurer shall:
10	(1) remove the waiver;
11	(2) not consider the condition or any complication to which
12	the waiver previously applied in making policy underwriting
13	determinations; and
14	(3) renew the policy in accordance with 45 CFR 148.122.
15	SECTION 3. IC 27-8-10-5.1 IS AMENDED TO READ AS
16	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 5.1. (a) A person is not
17	eligible for an association policy if the person is eligible for Medicaid.
18	A person other than a federally eligible individual may not apply for an
19	association policy unless the person has applied for Medicaid not more
20	than sixty (60) days before applying for the association policy.
21	(b) Except as provided in subsection (c), a person is not eligible for
22	an association policy if, at the effective date of coverage, the person has
23	or is eligible for coverage under any insurance plan that equals or
24	exceeds the minimum requirements for accident and sickness insurance
25	policies issued in Indiana as set forth in IC 27. However, an offer of
26	coverage described in IC 27-8-5-2.5(e), or IC 27-8-5-2.7,
27	IC 27-8-5-19.2(e), or IC 27-8-5-19.3 does not affect an individual's
28	eligibility for an association policy under this subsection. Coverage
29	under any association policy is in excess of, and may not duplicate,
30	coverage under any other form of health insurance.
31	(c) Except as provided in IC 27-13-16-4 and subsection (a), a person
32	is eligible for an association policy upon a showing that:
33	(1) the person has been rejected by one (1) carrier for coverage
34	under any insurance plan that equals or exceeds the minimum
35	requirements for accident and sickness insurance policies issued
36	in Indiana, as set forth in IC 27, without material underwriting
37	restrictions;
38	(2) an insurer has refused to issue insurance except at a rate
39	exceeding the association plan rate; or
40	(3) the person is a federally eligible individual.
41	For the purposes of this subsection, eligibility for Medicare coverage

does not disqualify a person who is less than sixty-five (65) years of



1	age from eligibility for an association policy.
2	(d) Coverage under an association policy terminates as follows:
3	(1) On the first date on which an insured is no longer a resident of
4	Indiana.
5	(2) On the date on which an insured requests cancellation of the
6	association policy.
7	(3) On the date of the death of an insured.
8	(4) At the end of the policy period for which the premium has
9	been paid.
0	(5) On the first date on which the insured no longer meets the
1	eligibility requirements under this section.
2	(e) An association policy must provide that coverage of a dependent
3	unmarried child terminates when the child becomes nineteen (19) years
4	of age (or twenty-five (25) years of age if the child is enrolled full-time
5	full time in an accredited educational institution). The policy must also
6	provide in substance that attainment of the limiting age does not
7	operate to terminate a dependent unmarried child's coverage while the
8	dependent is and continues to be both:
9	(1) incapable of self-sustaining employment by reason of mental
20	retardation or mental or physical disability; and
21	(2) chiefly dependent upon the person in whose name the contract
22	is issued for support and maintenance.
23	However, proof of such incapacity and dependency must be furnished
24	to the carrier within one hundred twenty (120) days of the child's
25	attainment of the limiting age, and subsequently as may be required by
26	the carrier, but not more frequently than annually after the two (2) year
27	period following the child's attainment of the limiting age.
28	(f) An association policy that provides coverage for a family
29	member of the person in whose name the contract is issued must, as to
0	the family member's coverage, also provide that the health insurance
31	benefits applicable for children are payable with respect to a newly
32	born child of the person in whose name the contract is issued from the
3	moment of birth. The coverage for newly born children must consist of
34	coverage of injury or illness, including the necessary care and treatment
35	of medically diagnosed congenital defects and birth abnormalities. If
66	payment of a specific premium is required to provide coverage for the
37	child, the contract may require that notification of the birth of a child
8	and payment of the required premium must be furnished to the carrier
9	within thirty-one (31) days after the date of birth in order to have the
10	coverage continued beyond the thirty-one (31) day period

(g) Except as provided in subsection (h), an association policy may contain provisions under which coverage is excluded during a period



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1	of three (3) months following the effective date of coverage as to a
2	given covered individual for preexisting conditions, as long as medical
3	advice or treatment was recommended or received within a period of
4	three (3) months before the effective date of coverage. This subsection
5	may not be construed to prohibit preexisting condition provisions in an
6	insurance policy that are more favorable to the insured.
7	(h) If a person applies for an association policy within six (6)
8	months after termination of the person's coverage under a health
9	insurance arrangement and the person meets the eligibility
10	requirements of subsection (c), then an association policy may not
11	contain provisions under which:
12	(1) coverage as to a given individual is delayed to a date after the
13	effective date or excluded from the policy; or
14	(2) coverage as to a given condition is denied;
15	on the basis of a preexisting health condition. This subsection may not
16	be construed to prohibit preexisting condition provisions in an
17	insurance policy that are more favorable to the insured.
18	(i) For purposes of this section, coverage under a health insurance
19	arrangement includes, but is not limited to, coverage pursuant to the
20	Consolidated Omnibus Budget Reconciliation Act of 1985.
21	SECTION 4. IC 27-8-13.5 IS ADDED TO THE INDIANA CODE
22	AS A <b>NEW</b> CHAPTER TO READ AS FOLLOWS [EFFECTIVE
23	JULY 1, 2005]:
24	Chapter 13.5. Health Benefit Mandate Option
25	Sec. 1. As used in this chapter, "health benefit mandate" means
26	any of the following requirements for coverage in, or an offering
27	of coverage that must be made in connection with the purchase of,
28	a policy of accident and sickness insurance, to the extent that the
29	coverage is not required under federal law:
30	(1) Newborn coverage under IC 27-8-5.6.
31	(2) Breast cancer screening related coverage under
32	IC 27-8-14.
33	(3) Morbid obesity related coverage under IC 27-8-14.1.
34	(4) Pervasive developmental disability related coverage under
35	IC 27-8-14.2.
36	(5) Diabetes related coverage under IC 27-8-14.5.
37	(6) Prostate cancer screening related coverage under
38	IC 27-8-14.7.
39	(7) Colorectal cancer screening related coverage under
40	IC 27-8-14.8.
41	(8) Off label drug treatment coverage under IC 27-8-20.

(9) Minimum maternity related benefits under IC 27-8-24.



1	(10) Inherited metabolic disease related coverage under	
2	IC 27-8-24.1.	
3	(11) Mastectomy related coverage under IC 27-8-5-26.	
4	(12) Mental illness related coverage under IC 27-8-5-15.6.	
5	(13) Dental anesthesia related coverage under IC 27-8-5-27.	
6	(14) Adopted child coverage under IC 27-8-5-21.	
7	Sec. 2. As used in this chapter, "insurer" refers to an insurer (as	
8	defined in IC 27-1-2-3) that issues or delivers a policy of accident	
9	and sickness insurance.	
0	Sec. 3. As used in this chapter, "policy of accident and sickness	
1	insurance" has the meaning set forth in IC 27-8-5-1.	
2	Sec. 4. As used in this chapter, "prospective purchaser" means	
.3	an:	
4	(1) individual who requests coverage under a policy of	
.5	accident and sickness insurance issued on an individual basis;	
.6	or	
.7	(2) employer that:	U
. 8	(A) employs not more than fifty (50) employees;	
9	(B) requests coverage for the employer's employees under	
20	a policy of accident and sickness insurance issued on a	
21	group basis; and	
22	(C) has not provided coverage for health care services (as	
23	defined in IC 27-13-1-18) for the employer's employees	
24	during the preceding calendar year.	-
25	Sec. 5. Notwithstanding any other law, an insurer may offer to	
26	a prospective purchaser a policy of accident and sickness insurance	
27	without complying with all health benefit mandates if:	
28	(1) when the offer is made, the insurer provides a list of the	V
29	health benefit mandates with which the offer does not comply;	
80	and	
31	(2) the policy offered includes the following:	
32	(A) Newborn coverage required under IC 27-8-5.6.	
33	(B) Diabetes related coverage required under IC 27-8-14.5.	
4	(C) If the prospective purchaser is described in section 4(2)	
55	of this chapter:	
56	(i) breast cancer screening related coverage required	
37	under IC 27-8-14;	
8	(ii) prostate cancer screening related coverage required	
19	under IC 27-8-14.7; and	
10	(iii) colorectal cancer screening related coverage	
-   2	required under IC 27-8-14.8.	



1	(E) Minimum maternity related benefits of examination
2	and testing of the newborn child required under
3	IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).
4	Sec. 6. An insurer that offers to a prospective purchaser a policy
5	of accident and sickness insurance described in section 5 of this
6	chapter shall also offer to the prospective purchaser a policy of
7	accident and sickness insurance in compliance with all health
8	benefit mandates.
9	Sec. 7. An insurer that issues or delivers a policy of accident and
10	sickness insurance described in section 5 of this chapter shall
11	provide to an individual insured under the policy of accident and
12	sickness insurance a written disclosure that:
13	(1) acknowledges that the policy of accident and sickness
14	insurance is not issued in compliance with all health benefit
15	mandates; and
16	(2) lists in summary form the health benefits:
17	(A) to which a health benefit mandate applies; and
18	(B) for which coverage is provided in the policy of accident
19	and sickness insurance.
20	SECTION 5. IC 27-8-29-6 IS AMENDED TO READ AS
21	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. As used in this
22	chapter, "external grievance" means the independent review under this
23	chapter of a:
24	(1) grievance filed under IC 27-8-28; or
25	(2) denial of coverage based on a waiver described in
26	IC 27-8-5-2.5, of IC 27-8-5-2.7, IC 27-8-5-19.2, or
27	IC 27-8-5-19.3.
28	SECTION 6. IC 27-8-29-12 IS AMENDED TO READ AS
29	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 12. An insurer shall
30	establish and maintain an external grievance procedure for the
31	resolution of external grievances regarding:
32	(1) an adverse determination of appropriateness;
33	(2) an adverse determination of medical necessity;
34	(3) a determination that a proposed service is experimental or
35	investigational; or
36	(4) a denial of coverage based on a waiver described in
37	IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or
38	IC 27-8-5-19.3;
39	made by an insurer or an agent of an insurer regarding a service
40	proposed by the treating health care provider.
41	SECTION 7. IC 27-8-29-13 IS AMENDED TO READ AS
42	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) An external



1	grievance procedure established under section 12 of this chapter must:
2	(1) allow a covered individual or a covered individual's
3	representative to file a written request with the insurer for an
4	external grievance review of the insurer's:
5	(A) appeal resolution under IC 27-8-28-17; or
6	(B) denial of coverage based on a waiver described in
7	IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or
8	IC 27-8-5-19.3;
9	not more than forty-five (45) days after the covered individual is
.0	notified of the resolution; and
.1	(2) provide for:
2	(A) an expedited external grievance review for a grievance
3	related to an illness, a disease, a condition, an injury, or a
4	disability if the time frame for a standard review would
5	seriously jeopardize the covered individual's:
6	(i) life or health; or
7	(ii) ability to reach and maintain maximum function; or
8	(B) a standard external grievance review for a grievance not
9	described in clause (A).
20	A covered individual may file not more than one (1) external grievance
21	of an insurer's appeal resolution under this chapter.
22	(b) Subject to the requirements of subsection (d), when a request is
23	filed under subsection (a), the insurer shall:
24	(1) select a different independent review organization for each
25	external grievance filed under this chapter from the list of
26	independent review organizations that are certified by the
27	department under section 19 of this chapter; and
28	(2) rotate the choice of an independent review organization
29	among all certified independent review organizations before
0	repeating a selection.
51	(c) The independent review organization chosen under subsection
32	(b) shall assign a medical review professional who is board certified in
3	the applicable specialty for resolution of an external grievance.
4	(d) The independent review organization and the medical review
35	professional conducting the external review under this chapter may not
66	have a material professional, familial, financial, or other affiliation with
57	any of the following:
8	(1) The insurer.
19	(2) Any officer, director, or management employee of the insurer.
10	(3) The health care provider or the health care provider's medical
1	group that is proposing the service.
12	(4) The facility at which the service would be provided



1	(3) The development of manufacture of the principal drug, device,
2	procedure, or other therapy that is proposed for use by the treating
3	health care provider.
4	(6) The covered individual requesting the external grievance
5	review.
6	However, the medical review professional may have an affiliation
7	under which the medical review professional provides health care
8	services to covered individuals of the insurer and may have an
9	affiliation that is limited to staff privileges at the health facility, if the
10	affiliation is disclosed to the covered individual and the insurer before
11	commencing the review and neither the covered individual nor the
12	insurer objects.
13	(e) A covered individual shall not pay any of the costs associated
14	with the services of an independent review organization under this
15	chapter. All costs must be paid by the insurer.
16	SECTION 8. IC 27-8-29-15 IS AMENDED TO READ AS
17	FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. (a) An independent
18	review organization shall:
19	(1) for an expedited external grievance filed under section
20	13(a)(2)(A) of this chapter, within three (3) business days after
21	the external grievance is filed; or
22	(2) for a standard appeal filed under section 13(a)(2)(B) of this
23	chapter, within fifteen (15) business days after the appeal is filed;
24	make a determination to uphold or reverse the insurer's appeal
25	resolution under IC 27-8-28-17 based on information gathered from the
26	covered individual or the covered individual's designee, the insurer,
27	and the treating health care provider, and any additional information
28	that the independent review organization considers necessary and
29	appropriate.
30	(b) When making the determination under this section, the
31	independent review organization shall apply:
32	(1) standards of decision making that are based on objective
33	clinical evidence; and
34	(2) the terms of the covered individual's accident and sickness
35	insurance policy.
36	(c) In an external grievance described in section 12(4) of this
37	chapter, the insurer bears the burden of proving that the insurer
38	properly denied coverage for a condition, complication, service, or
39	treatment because the condition, complication, service, or treatment is
40	directly related to a condition for which coverage has been waived
41	under IC 27-8-5-2.5, or IC 27-8-5-2.7, IC 27-8-5-19.2, or



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IC 27-8-5-19.3.

1	(d) The independent review organization shall notify the insurer and	
2	the covered individual of the determination made under this section:	
3	(1) for an expedited external grievance filed under section	
4	13(a)(2)(A) of this chapter, within twenty-four (24) hours after	
5	making the determination; and	
6	(2) for a standard external grievance filed under section	
7	13(a)(2)(B) of this chapter, within seventy-two (72) hours after	
8	making the determination.	
9	SECTION 9. IC 27-13-1-17.6 IS ADDED TO THE INDIANA	
10	CODE AS A <b>NEW</b> SECTION TO READ AS FOLLOWS	
11	[EFFECTIVE JULY 1, 2005]: Sec. 17.6. "Health benefit mandate"	
12	means any of the following requirements for coverage in, or an	
13	offering of coverage that must be made in connection with the	
14	purchase of, an individual contract or a group contract, to the	
15	extent that the coverage is not required under federal law:	_
16	(1) Newborn coverage under IC 27-8-5.6.	
17	(2) Breast cancer screening related coverage under	
18	IC 27-13-7-15.3.	
19	(3) Morbid obesity related coverage under IC 27-13-7-14.5.	
20	(4) Pervasive developmental disability related coverage under	
21	IC 27-13-7-14.7.	
22	(5) Diabetes related coverage under IC 27-8-14.5.	
23	(6) Prostate cancer screening related coverage under	
24	IC 27-13-7-16.	_
25	(7) Colorectal cancer screening related coverage under	
26	IC 27-13-7-17.	
27	(8) Off label drug treatment coverage under IC 27-8-20.	
28	(9) Minimum maternity related benefits under IC 27-8-24.	y
29	(10) Inherited metabolic disease related coverage under	
30	IC 27-13-7-18.	
31	(11) Mastectomy related coverage under IC 27-13-7-14.	
32	(12) Mental illness related coverage under IC 27-13-7-14.8.	
33	(13) Dental anesthesia related coverage under IC 27-13-7-15.	
34	(14) Adopted child coverage under IC 27-8-5-21. SECTION 10. IC 27-13-1-27.8 IS ADDED TO THE INDIANA	
35		
36	CODE AS A NEW SECTION TO READ AS FOLLOWS	
37	[EFFECTIVE JULY 1, 2005]: Sec. 27.8. "Prospective purchaser"	
38	means an:	
39 40	(1) individual who requests coverage under an individual	
40 41	contract; or	
41 42	(2) employer that:  (A) employs not more than fifty (50) employees:	
<b></b> /	LA LEMINOVS HOLIMOLE HIND THIV LAM EMMOVEES.	



1	(B) requests coverage for the employer's employees under	
2	a group contract; and	
3	(C) has not provided coverage for health care services for	
4	the employer's employees during the preceding calendar	
5	year.	
6	SECTION 11. IC 27-13-7.5 IS ADDED TO THE INDIANA CODE	
7	AS A <b>NEW</b> CHAPTER TO READ AS FOLLOWS [EFFECTIVE	
8	JULY 1, 2005]:	
9	Chapter 7.5. Health Benefit Mandate Option	
10	Sec. 1. Notwithstanding any other law, a health maintenance	7
11	organization may offer to a prospective purchaser an individual	
12	contract or a group contract without complying with all health	
13	benefit mandates if:	
14	(1) when the offer is made, the health maintenance	
15	organization provides a list of the health benefit mandates	
16	with which the offer does not comply; and	r
17	(2) the contract includes the following:	L
18	(A) Newborn coverage that is substantially similar to the	
19	coverage required under IC 27-8-5.6.	
20	(B) Diabetes related coverage required under IC 27-8-14.5.	
21	(C) If the prospective purchaser is described in	1
22	IC 27-13-1-27.8(2):	
23	(i) breast cancer screening related coverage required	ľ
24	under IC 27-13-7-15.3;	
25	(ii) prostate cancer screening related coverage required	
26	under IC 27-13-7-16; and	
27	(iii) colorectal cancer screening related coverage	A
28	required under IC 27-13-7-17.	Ŧ
29	(D) Adopted child coverage required under IC 27-8-5-21.	
30	(E) Minimum maternity related benefits of examination	
31	and testing of the newborn child required under	
32	IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).	
33	Sec. 2. A health maintenance organization that offers to a	
34	prospective purchaser an individual contract or a group contract	
35	described in section 1 of this chapter shall also offer to the	
36	prospective purchaser an individual contract or a group contract	
37	in compliance with all health benefit mandates.	
38	Sec. 3. A health maintenance organization that enters into or	
39	delivers an individual contract or a group contract described in	
40	section 1 of this chapter shall provide to an enrollee a written	
41	disclosure that:	
42	(1) acknowledges that the individual contract or group	



1	contract is not entered into in compliance with all health
2	benefit mandates; and
3	(2) lists in summary form the health benefits:
4	(A) to which a health benefit mandate applies; and
5	(B) for which coverage is provided in the individual
6	contract or group contract.
7	SECTION 12. [EFFECTIVE JULY 1, 2005] (a) As used in this
8	SECTION, "department" refers to the department of insurance
9	created by IC 27-1-1-1.
10	(b) An insurer that issues or delivers a policy of accident and
11	sickness insurance described in IC 27-8-13.5-5, as added by this
12	act, and a health maintenance organization that enters into or
13	delivers a contract described in IC 27-13-7.5-1, as added by this
14	act, shall report the following information to the department not
15	later than November 15, 2006:
16	(1) The number of policies or contracts described in this
17	subsection that are issued or delivered by the insurer or
18	entered into or delivered by the health maintenance
19	organization and the number of individuals covered under
20	each policy or contract.
21	(2) The premium for each policy or contract described in this
22	subsection.
23	(3) The difference between:
24	(A) the premium described in this subsection; and
25	(B) the premium of any other policy or contract offered to
26	a prospective purchaser that purchased a policy or
27	contract described in this subsection.
28	(c) Not later than December 1, 2006, the department shall
29	compile the information reported to the department under
30	subsection (b) and report the information to the legislative council
31	in an electronic format under IC 5-14-6. The department:
32	(1) shall include in the report information concerning the
33	number of uninsured individuals in Indiana; and
34	(2) may include any other information in the report that the
35	department determines is relevant.
36	(d) This SECTION expires December 31, 2006.
37	SECTION 13. [EFFECTIVE JULY 1, 2005] IC 27-8-5-2.7, as
38	added by this act, applies to a policy of accident and sickness
39	insurance that is issued or delivered after June 30, 2005.
40	SECTION 14. [EFFECTIVE JULY 1, 2005] (a) An insurer that
41	issues a policy of accident and sickness insurance that contains a

waiver under IC 27-8-5-2.7 or IC 27-8-5-19.3, both as added by this



1	act, shall submit to the commissioner of the department of	
2	insurance the following information for the reporting periods	
3	specified under subsection (b) on a form prescribed by the	
4	commissioner:	
5	(1) The number of policies and certificates that the insurer	
6	issued with a waiver.	
7	(2) A list of specified conditions that the insurer waived.	
8	(3) The number of waivers issued for each specified condition	
9	listed under subdivision (2).	
10	(4) The number of waivers issued categorized by the period of	
11	time for which coverage of a specified condition was waived.	
12	(5) The number of applicants who were denied insurance	
13	coverage by the insurer because of a specified condition.	
14	(b) An insurer shall submit to the commissioner of the	
15	department of insurance the information required under	
16	subsection (a) as follows:	
17	(1) Not later than September 1, 2006, for the reporting period	U
18	July 1, 2005, through June 30, 2006.	
19	(2) Not later than September 1, 2007, for the reporting period	
20	July 1, 2006, through June 30, 2007.	
21	(c) The commissioner of the department of insurance shall	
22	forward the information submitted:	
23	(1) under subsection (b)(1) not later than November 1, 2006;	
24	and	
25	(2) under subsection (b)(2) not later than November 1, 2007;	
26	to the legislative council in an electronic format under IC 5-14-6.	
27	(d) The commissioner of the department of insurance shall	
28	compile the information submitted under subsection (b) and, not	V
29	later than November 1, 2007, report the information to the	
30	legislative council in an electronic format under IC 5-14-6.	
31	(e) This SECTION expires June 30, 2008.	



#### COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1075, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, line 3, delete "As used in this section, the term "policy of".

Page 1, delete lines 4 through 17.

Page 2, delete lines 1 through 2.

Page 2, line 3, delete "(b)".

Run in page 1, line 3, through page 2, line 3.

Page 3, line 6, delete "(c)" and insert "(b)".

Page 3, line 6, delete "(b)," and insert "(a),".

and when so amended that said bill do pass.

(Reference is to HB 1075 as introduced.)

RIPLEY, Chair

Committee Vote: yeas 9, nays 2.

#### **HOUSE MOTION**

Mr. Speaker: I move that House Bill 1075 be amended to read as follows:

Page 2, line 34, delete "or".

Page 2, line 35, delete "." and insert "; or

(3) diabetes as required under IC 27-8-14.5.".

Page 4, line 10, delete "or".

Page 4, line 11, delete "." and insert "; or

(3) diabetes as required under IC 27-8-14.5.".

(Reference is to HB 1075 as printed January 14, 2005.)

FRY

#### HOUSE MOTION

Mr. Speaker: I move that House Bill 1075 be amended to read as follows:

Page 2, line 31, delete "," and insert ": (1)".











Page 2, line 34, delete "(1)", begin a new line double block indented and insert:

"(A)".

Page 2, line 35, delete "(2)", begin a new line double block indented and insert:

"(B)".

Page 2, line 35, delete "." and insert "; and

(2) an insurer that issues an individual policy of accident and sickness insurance shall comply with the requirements concerning victims of abuse under IC 27-8-24.3.".

Page 4, line 8, delete "," and insert ":

(1)"

Page 4, line 10, delete "(1)", begin a new line double block indented and insert:

"(A)".

Page 4, line 11, delete "(2)", begin a new line double block indented and insert:

"(B)".

Page 4, line 11, delete "." and insert "; and

(2) an insurer that issues a policy described in subsection (a) shall comply with the requirements concerning victims of abuse under IC 27-8-24.3.".

(Reference is to HB 1075 as printed January 14, 2005.)

FRY

### COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1075, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, line 6, delete "if all of the" and insert "if:

- (1) the waiver period does not exceed ten (10) years; and
- (2) all of the following conditions are met:".

Page 1, delete line 7.

Page 1, line 8, delete "(1)", begin a new line double block indented and insert:

"(A)".

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Page 1, line 12, delete "(2)", begin a new line double block indented and insert:

"(B)".

Page 1, line 13, delete "(A)", begin a new line triple block indented and insert:

"(i)"

Page 1, line 14, delete "(B)", begin a new line triple block indented and insert:

"(ii)".

Page 1, line 15, beginning with "include" begin a new line double block indented.

Page 2, line 1, delete "(3)", begin a new line double block indented and insert:

"(C)"

Page 2, line 2, delete "(A)", begin a new line triple block indented and insert:

"(i)'

Page 2, line 3, delete "(B)", begin a new line triple block indented and insert:

"(ii)"

Page 2, line 4, beginning with "do" begin a new line double block indented.

Page 2, line 5, delete "(4)", begin a new line double block indented and insert:

"(D)"

Page 2, line 8, delete "(5)", begin a new line double block indented and insert:

"Œ)"

Page 2, line 8, delete "to review the waiver upon request if:" and insert "to:

- (i) review the underwriting basis for the waiver upon request one (1) time per year; and
- (ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.".

Page 2, delete lines 9 through 16.

Page 2, line 17, delete "(6)", begin a new line double block indented and insert:

"(F)".

Page 2, line 21, delete "(7)", begin a new line double block indented and insert:

"(G) The waiver of coverage does not apply to coverage required under state law.

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(H)".

Page 2, line 25, delete "(1)" and insert "(2)(A)".

Page 2, line 26, delete "(2)" and insert "(2)(B)".

Page 2, between lines 39 and 40, begin a new paragraph and insert:

- "(c) An insurer may not, on the basis of a waiver contained in a policy as provided in subsection (a), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:
  - (1) written notice under subsection (a)(2)(A); and
  - (2) offer of coverage and policy under subsection (a)(2)(B).
- (d) An individual who is covered under a policy that includes a waiver under subsection (a) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.
- (e) An insurer that removes a waiver under subsection (a)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.
- (f) Upon the expiration of the waiver period allowed under this section, the insurer shall:
  - (1) remove the waiver;
  - (2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
  - (3) renew the policy in accordance with 45 CFR 148.122.".

Page 3, line 10, delete "if all of the following conditions are met:" and insert "**if:** 

- (1) the waiver period does not exceed ten (10) years; and
- (2) all of the following conditions are met:".

Page 3, line 11, delete "(1)", begin a new line double block indented and insert:

"(A)"

Page 3, line 15, delete "(2)", begin a new line double block indented and insert:

"(B)"

Page 3, line 16, delete "(A)", begin a new line triple block indented and insert:

"(i)"

Page 3, line 17, delete "(B)", begin a new line triple block indented and insert:

"(ii)".











Page 3, line 18, beginning with "include" begin a new line double block indented.

Page 3, line 21, delete "(3)", begin a new line double block indented and insert:

"(C)".

Page 3, line 22, delete "(A)", begin a new line triple block indented and insert:

"(i)".

Page 3, line 23, delete "(B)", begin a new line triple block indented and insert:

"(ii)".

Page 3, line 24, beginning with "do" begin a new line double block indented.

Page 3, line 25, delete "(4)", begin a new line double block indented and insert:

"(D)".

Page 3, line 28, delete "(5)", begin a new line double block indented and insert:

"(E)".

Page 3, line 28, delete "to review the waiver upon request if:" and insert "to:

- (i) review the underwriting basis for the waiver upon request one (1) time per year; and
- (ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.".

Page 3, delete lines 29 through 36.

Page 3, line 37, delete "(6)", begin a new line double block indented and insert:

"(F)".

Page 3, line 42, delete "(7)", begin a new line double block indented and insert:

"(G) The waiver of coverage does not apply to coverage required under state law.

(H)".

Page 4, line 4, delete "(b)(1)" and insert "(b)(2)(A)".

Page 4, line 6, delete "(b)(2)" and insert "(b)(2)(B)".

Page 4, delete lines 8 through 20, begin a new paragraph and insert:

- "(d) An insurer may not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition, complication, service, or treatment that is not specified as required in the:
  - (1) written notice under subsection (b)(2)(A); and











- (2) offer of coverage and certificate of coverage under subsection (b)(2)(B).
- (e) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.
- (f) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.
- (g) An insurer that removes a waiver under subsection (b)(2)(E) shall not consider the condition or any complication to which the waiver previously applied in making policy renewal and underwriting determinations.
- (h) Upon the expiration of the waiver period allowed under this section, the insurer shall:
  - (1) remove the waiver;
  - (2) not consider the condition or any complication to which the waiver previously applied in making policy underwriting determinations; and
  - (3) renew the policy in accordance with 45 CFR 148.122.". Page 5, line 20, strike "full-time" and insert "full time".

Page 6, between lines 26 and 27, begin a new paragraph and insert: "SECTION 4. IC 27-8-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]:

### Chapter 13.5. Health Benefit Mandate Option

- Sec. 1. As used in this chapter, "health benefit mandate" means any of the following requirements for coverage in, or an offering of coverage that must be made in connection with the purchase of, a policy of accident and sickness insurance, to the extent that the coverage is not required under federal law:
  - (1) Newborn coverage under IC 27-8-5.6.
  - (2) Breast cancer screening related coverage under IC 27-8-14.
  - (3) Morbid obesity related coverage under IC 27-8-14.1.
  - (4) Pervasive developmental disability related coverage under IC 27-8-14.2.
  - (5) Diabetes related coverage under IC 27-8-14.5.
  - (6) Prostate cancer screening related coverage under IC 27-8-14.7.









- (7) Colorectal cancer screening related coverage under IC 27-8-14.8.
- (8) Off label drug treatment coverage under IC 27-8-20.
- (9) Minimum maternity related benefits under IC 27-8-24.
- (10) Inherited metabolic disease related coverage under IC 27-8-24.1.
- (11) Mastectomy related coverage under IC 27-8-5-26.
- (12) Mental illness related coverage under IC 27-8-5-15.6.
- (13) Dental anesthesia related coverage under IC 27-8-5-27.
- (14) Adopted child coverage under IC 27-8-5-21.
- Sec. 2. As used in this chapter, "insurer" refers to an insurer (as defined in IC 27-1-2-3) that issues or delivers a policy of accident and sickness insurance.
- Sec. 3. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1.
- Sec. 4. As used in this chapter, "prospective purchaser" means an:
  - (1) individual who requests coverage under a policy of accident and sickness insurance issued on an individual basis; or
  - (2) employer that:
    - (A) employs not more than fifty (50) employees;
    - (B) requests coverage for the employer's employees under a policy of accident and sickness insurance issued on a group basis; and
    - (C) has not provided coverage for health care services (as defined in IC 27-13-1-18) for the employer's employees during the preceding calendar year.
- Sec. 5. Notwithstanding any other law, an insurer may offer to a prospective purchaser a policy of accident and sickness insurance without complying with all health benefit mandates if:
  - (1) when the offer is made, the insurer provides a list of the health benefit mandates with which the offer does not comply; and
  - (2) the policy offered includes the following:
    - (A) Newborn coverage required under IC 27-8-5.6.
    - (B) Diabetes related coverage required under IC 27-8-14.5.
    - (C) If the prospective purchaser is described in section 4(2) of this chapter:
      - (i) breast cancer screening related coverage required under IC 27-8-14;
      - (ii) prostate cancer screening related coverage required



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under IC 27-8-14.7; and

- (iii) colorectal cancer screening related coverage required under IC 27-8-14.8.
- (D) Adopted child coverage required under IC 27-8-5-21.
- (E) Minimum maternity related benefits of examination and testing of the newborn child required under IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).

Sec. 6. An insurer that offers to a prospective purchaser a policy of accident and sickness insurance described in section 5 of this chapter shall also offer to the prospective purchaser a policy of accident and sickness insurance in compliance with all health benefit mandates.

Sec. 7. An insurer that issues or delivers a policy of accident and sickness insurance described in section 5 of this chapter shall provide to an individual insured under the policy of accident and sickness insurance a written disclosure that:

- (1) acknowledges that the policy of accident and sickness insurance is not issued in compliance with all health benefit mandates; and
- (2) lists in summary form the health benefits:
  - (A) to which a health benefit mandate applies; and
  - (B) for which coverage is provided in the policy of accident and sickness insurance.

SECTION 5. IC 27-8-29-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

- (1) grievance filed under IC 27-8-28; or
- (2) denial of coverage based on a waiver described in IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3.

SECTION 6. IC 27-8-29-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

- (1) an adverse determination of appropriateness;
- (2) an adverse determination of medical necessity;
- (3) a determination that a proposed service is experimental or investigational; or
- (4) a denial of coverage based on a waiver described in IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3;

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made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 7. IC 27-8-29-13 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

- (1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:
  - (A) appeal resolution under IC 27-8-28-17; or
  - (B) denial of coverage based on a waiver described in IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3;

not more than forty-five (45) days after the covered individual is notified of the resolution; and

- (2) provide for:
  - (A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:
    - (i) life or health; or
    - (ii) ability to reach and maintain maximum function; or
  - (B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

- (b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:
  - (1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and
  - (2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.
- (c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.
- (d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:
  - (1) The insurer.











- (2) Any officer, director, or management employee of the insurer.
- (3) The health care provider or the health care provider's medical group that is proposing the service.
- (4) The facility at which the service would be provided.
- (5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.
- (6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual shall not pay any of the costs associated with the services of an independent review organization under this chapter. All costs must be paid by the insurer.

SECTION 8. IC 27-8-29-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 15. (a) An independent review organization shall:

- (1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within three (3) business days after the external grievance is filed; or
- (2) for a standard appeal filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed; make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.
- (b) When making the determination under this section, the independent review organization shall apply:
  - (1) standards of decision making that are based on objective clinical evidence; and
  - (2) the terms of the covered individual's accident and sickness insurance policy.
- (c) In an external grievance described in section 12(4) of this chapter, the insurer bears the burden of proving that the insurer properly denied coverage for a condition, complication, service, or











treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5, or IC 27-8-5-19.2, or IC 27-8-5-19.3.

- (d) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:
  - (1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and
  - (2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

SECTION 9. IC 27-13-1-17.6 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: Sec. 17.6. "Health benefit mandate" means any of the following requirements for coverage in, or an offering of coverage that must be made in connection with the purchase of, an individual contract or a group contract, to the extent that the coverage is not required under federal law:

- (1) Newborn coverage under IC 27-8-5.6.
- (2) Breast cancer screening related coverage under IC 27-13-7-15.3.
- (3) Morbid obesity related coverage under IC 27-13-7-14.5.
- (4) Pervasive developmental disability related coverage under IC 27-13-7-14.7.
- (5) Diabetes related coverage under IC 27-8-14.5.
- (6) Prostate cancer screening related coverage under IC 27-13-7-16.
- (7) Colorectal cancer screening related coverage under IC 27-13-7-17.
- (8) Off label drug treatment coverage under IC 27-8-20.
- (9) Minimum maternity related benefits under IC 27-8-24.
- (10) Inherited metabolic disease related coverage under IC 27-13-7-18.
- (11) Mastectomy related coverage under IC 27-13-7-14.
- (12) Mental illness related coverage under IC 27-13-7-14.8.
- (13) Dental anesthesia related coverage under IC 27-13-7-15.
- (14) Adopted child coverage under IC 27-8-5-21.

SECTION 10. IC 27-13-1-27.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]: **Sec. 27.8. "Prospective purchaser" means an:** 











- (1) individual who requests coverage under an individual contract; or
- (2) employer that:
  - (A) employs not more than fifty (50) employees;
  - (B) requests coverage for the employer's employees under a group contract; and
  - (C) has not provided coverage for health care services for the employer's employees during the preceding calendar year.

SECTION 11. IC 27-13-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2005]:

### Chapter 7.5. Health Benefit Mandate Option

- Sec. 1. Notwithstanding any other law, a health maintenance organization may offer to a prospective purchaser an individual contract or a group contract without complying with all health benefit mandates if:
  - (1) when the offer is made, the health maintenance organization provides a list of the health benefit mandates with which the offer does not comply; and
  - (2) the contract includes the following:
    - (A) Newborn coverage that is substantially similar to the coverage required under IC 27-8-5.6.
    - (B) Diabetes related coverage required under IC 27-8-14.5.
    - (C) If the prospective purchaser is described in IC 27-13-1-27.8(2):
      - (i) breast cancer screening related coverage required under IC 27-13-7-15.3;
      - (ii) prostate cancer screening related coverage required under IC 27-13-7-16; and
      - (iii) colorectal cancer screening related coverage required under IC 27-13-7-17.
    - (D) Adopted child coverage required under IC 27-8-5-21.
    - (E) Minimum maternity related benefits of examination and testing of the newborn child required under IC 27-8-24-4(a)(2) and IC 27-8-24-4(a)(3).
- Sec. 2. A health maintenance organization that offers to a prospective purchaser an individual contract or a group contract described in section 1 of this chapter shall also offer to the prospective purchaser an individual contract or a group contract in compliance with all health benefit mandates.
  - Sec. 3. A health maintenance organization that enters into or



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delivers an individual contract or a group contract described in section 1 of this chapter shall provide to an enrollee a written disclosure that:

- (1) acknowledges that the individual contract or group contract is not entered into in compliance with all health benefit mandates; and
- (2) lists in summary form the health benefits:
  - (A) to which a health benefit mandate applies; and
  - (B) for which coverage is provided in the individual contract or group contract.

SECTION 12. [EFFECTIVE JULY 1, 2005] (a) As used in this SECTION, "department" refers to the department of insurance created by IC 27-1-1-1.

- (b) An insurer that issues or delivers a policy of accident and sickness insurance described in IC 27-8-13.5-5, as added by this act, and a health maintenance organization that enters into or delivers a contract described in IC 27-13-7.5-1, as added by this act, shall report the following information to the department not later than November 15, 2006:
  - (1) The number of policies or contracts described in this subsection that are issued or delivered by the insurer or entered into or delivered by the health maintenance organization and the number of individuals covered under each policy or contract.
  - (2) The premium for each policy or contract described in this subsection.
  - (3) The difference between:
    - (A) the premium described in this subsection; and
    - (B) the premium of any other policy or contract offered to a prospective purchaser that purchased a policy or contract described in this subsection.
- (c) Not later than December 1, 2006, the department shall compile the information reported to the department under subsection (b) and report the information to the legislative council in an electronic format under IC 5-14-6. The department:
  - (1) shall include in the report information concerning the number of uninsured individuals in Indiana; and
  - (2) may include any other information in the report that the department determines is relevant.
  - (d) This SECTION expires December 31, 2006.".

Page 6, line 27, delete "and" and insert ",".

Page 6, line 28, delete "IC 27-8-5-19.3, both".



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Page 6, line 28, delete "apply" and insert "applies".

Page 6, line 29, delete ", delivered, amended," and insert "or delivered".

Page 6, line 30, delete "or renewed".

Page 6, after line 30, begin a new paragraph and insert:

"SECTION 14. [EFFECTIVE JULY 1, 2005] (a) An insurer that issues a policy of accident and sickness insurance that contains a waiver under IC 27-8-5-2.7 or IC 27-8-5-19.3, both as added by this act, shall submit to the commissioner of the department of insurance the following information for the reporting periods specified under subsection (b) on a form prescribed by the commissioner:

- (1) The number of policies and certificates that the insurer issued with a waiver.
- (2) A list of specified conditions that the insurer waived.
- (3) The number of waivers issued for each specified condition listed under subdivision (2).
- (4) The number of waivers issued categorized by the period of time for which coverage of a specified condition was waived.
- (5) The number of applicants who were denied insurance coverage by the insurer because of a specified condition.
- (b) An insurer shall submit to the commissioner of the department of insurance the information required under subsection (a) as follows:
  - (1) Not later than September 1, 2006, for the reporting period July 1, 2005, through June 30, 2006.
  - (2) Not later than September 1, 2007, for the reporting period July 1, 2006, through June 30, 2007.
- (c) The commissioner of the department of insurance shall forward the information submitted:
  - (1) under subsection (b)(1) not later than November 1, 2006; and
- (2) under subsection (b)(2) not later than November 1, 2007; to the legislative council in an electronic format under IC 5-14-6.
- (d) The commissioner of the department of insurance shall compile the information submitted under subsection (b) and, not later than November 1, 2007, report the information to the legislative council in an electronic format under IC 5-14-6.
  - (e) This SECTION expires June 30, 2008.".











Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1075 as reprinted January 25, 2005.)

MILLER, Chairperson

Committee Vote: Yeas 6, Nays 3.

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